LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349, GADSDEN, AL 35902

Authorization to Release Information

(This Authorization is for records to be released.)

Please have the claimant (sick or injured person) complete the following:

1. List Names, Addresses and Phone Numbers of any and all Physicians, Clinics or Hospitals Consulted in the ***last 5 years***
2. Patient's Full Name
3. Patient's Date of Birth
4. Signature
5. Date

Patient Name____Date of Birth_____________________

Physician/Hospital Name____

Address____

Condition____Date of Service___________Phone__________________

Physician/Hospital Name____

Address____

Condition____Date of Service___________Phone__________________

Physician/Hospital Name____

Address____

Condition____Date of Service___________Phone__________________

Physician/Hospital Name____

Address____

Condition____Date of Service___________Phone__________________

I hereby authorize the above person or entity to provide Life Insurance Company of Alabama, or to Lab One/Exam One/SBSI on the behalf of Life Insurance Company of Alabama, information, data or records concerning advice, care, treatment or health history provided to the patient, employee or deceased named above, including information relating to mental illness, disability, patient account information, use of drugs or alcohol, AIDS, ARC (Aids related complex) or HIV virus and employment related information.

Special Instructions:

I understand that the information disclosed pursuant to the Authorization shall be used only for the purpose of evaluating my application and/or claim for insurance benefits and that my authorized representative or I will receive a copy of the authorization upon request, and I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and my application and/or claim for insurance benefits can not be determined without providing authorization as provided herein, and information disclosed pursuant to this authorization is not subject to redisclosure except as authorized by me or by law.

The Information that is used or disclosed based on this authorization may be re-disclosed by those who receive the information and may no longer be protected by the federal health information privacy law. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

I agree that a photo static copy of this authorization shall be considered as effective and valid as the original. This authorization shall be effective until withdrawn in writing or by me; or until my claim for benefits (or application for insurance coverage) has been determined, whichever occurs first.

____
Name (Please Print)

____ _________________________________
Signature Date

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